Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL MRI & DIAGNOSTICS
1346 CAMPBELL ROAD
HOUSTON TX 77055

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-09-6117-01

MFDR Date Received
February 17, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The code 72275-TC is the primary procedure code and it is not bundled. The Rule 133.304 states that the carrier must develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided receive a similar reimbursement."

Amount in Dispute: $382.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed charges for procedure code 72275 are denied as being global to the primary procedure code 62264 also billed for this date. Documentation from the Medicare Correct Coding Guide is enclosed. Documentation submitted does not support billing procedure code 90765 or Q9967 therefore the billed charges remain denied."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2008	90765 and Q9967	$301.88	$0.00
October 29, 2008	72275-TC	$80.36	$80.36
TOTAL		$382.24	$80.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - D20 – No denial description was provided on the EOB
   - B291 – This is a bundled or non covered procedure based on Medicare Guidelines; no separate payment allowed
   - 150 – No denial description was provided on the EOB
   - X901 – Documentation does not support level of service billed
   - Z605 – The charge exceeds the scheduled allowance for multiple procedures
   - P303 – This service was reviewed in accordance with your contract

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement for CPT codes 72275-TC and 90765?
4. Did the requestor submit documentation to support fair and reasonable reimbursement for HCPCS code Q9967?

Findings

1. The insurance carrier reduced disputed services with reason code "Z605 – The charge exceeds the scheduled allowance for multiple procedures" and "P303 – This service was reviewed in accordance with your contract." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on November 2, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT codes72275-TC, 90765 and Q9967 rendered on October 29, 2008. The division completed NCCI edits to identify edit conflicts that may affect reimbursement. The requestor billed the following CPT and HCPCS codes on October 29, 2008; 72275-TC, 36000-59, 99144-59, A4550, J2001, J2250, Q9967, J3301, 90765-59, 99499-59, 94760-59 and 77003-TC. The following NCCI edits were identified:

   "Per CCI Guidelines, Procedure Code 77003 [FLUORO NEEDLE/CATH SPINE/PARASPINAL DX/THER] has a CCI conflict with Procedure Code 72275 [EPIDUROGRAPY RS&I]. Review documentation to determine if a modifier is appropriate."

   "Per CCI Guidelines, Procedure Code 36000 [INTRODUCTION NEEDLE/INTRACATHETER VEIN] has a CCI conflict with Procedure Code 99144 [MODERATE SEDATJ SAME PHYS/QHP 5/>YRS INIT 30 MIN]. Review documentation to determine if a modifier is appropriate."

   "Per CCI Guidelines, Procedure Code 94760 has a CCI Conflict with Procedure Code 99144. A modifier is not allowed."

   The division finds no NCCI edit conflicts with the disputed CPT codes; 72275-TC, 90765 and Q9967 rendered on October 29, 2008, as a result, the division will review the disputed CPT codes pursuant to 28 Texas Administrative Code § 134.203 (c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Per 28 Texas Administrative Code § 134.203 “(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

The requestor seeks reimbursement for CPT code 72275 with modifier –TC. The modifier –TC identifies the following, “Technical component. Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.”

Reimbursement is therefore calculated for services rendered for the technical component. The MAR reimbursement for CPT code 72275-TC is $104.27, the requestor seeks reimbursement in the amount of $80.36, therefore this amount is recommended.

4. Per 28 Texas Administrative Code § 134.203 “(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   Per 28 Texas Administrative Code § 134.203 "(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   The disputed CPT 90765 and HCPCS code Q9967 are subject to the provisions of 28 Texas Administrative Code §134.1.

   This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection 134.1(f), which states that “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Former 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:

   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for reimbursement for CPT code 90765 and HCPCS code Q9967 is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended for CPT code90765 and HCPCS code Q9967.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $80.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $80.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.